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STANDARDS

Leadership

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LEADERSHIP

Accreditation Canada's Leadership standards help Canadian health care leaders pursue excellence in leadership within organizations that have a true commitment to client- and family-centred care. They are based on research and best practice and align with the Framework for the Analysis of Management in Health Care Organizations and Proposed Standards for Practice, researched and developed by J.L. Denis et al. (2006). The standards address leadership functions across and throughout all levels of the organization, rather than individual or position-specific capabilities. They clarify the requirements for effective operational and performance management supports, decision-making structures, and infrastructure needed to drive excellence and quality improvement with the primary focus being on creating a culture focused on client- and family- centered care.

Accreditation is one of the most effective ways for organizations to regularly and consistently examine and improve the quality of their services. The standards provide a tool for organizations to embed accreditation and quality improvement activities into their daily operations with the primary focus being on including the client and family as true partners in service delivery.

Client- and family-centred care is an approach that guides all aspects of planning, delivering and evaluating services. The focus is always on creating and nurturing mutually beneficial partnerships among the organization's staff and the clients and families they serve. Providing client- and family-centred care means working collaboratively with clients and their families to provide care that is respectful, compassionate, culturally safe, and competent, while being responsive to their needs, values, cultural backgrounds and beliefs, and preferences (adapted from the Institute for Patient- and Family-Centered Care (IPFCC) 2008 and Saskatchewan Ministry of Health 2011).

Accreditation Canada has adopted the four values that are fundamental to this approach, as outlined by the IPFCC, and integrated into the standards. The values are:

1. Dignity and respect: Listening to and honouring client and family perspectives and choices. Client and family knowledge, values, beliefs, and cultural backgrounds are incorporated into the planning and delivery of care.

2. Information sharing: Communicating and sharing complete and unbiased information with clients and families in ways that are affirming and useful. Clients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.

3. Partnership and participation: Encouraging and supporting clients and families to participate in care and decision making to the extent that they wish.

4. Collaboration: Collaborating with clients and families in policy and program development, implementation and evaluation, facility design, professional education, and delivery of care.

The Leadership standards are grouped into four sections that each address a key leadership responsibility that organizations must have in place as part of their pursuit of quality and safety.

The four sections are:

Creating and sustaining a caring culture: Addresses identifying, strengthening, and disseminating the culture and values throughout the organization. In particular, it addresses the need for health care organizations to create a culture that supports a safe and healthy work environment and ongoing quality improvement.

Planning and designing services: Addresses the organization's ability to assess trends in the environment, including the service needs of the populations it serves, and use that information to plan its structures, management systems, and services. It also deals with the organization's relationships with stakeholders and its processes to manage change.

Allocating resources and building infrastructure: Addresses managing resources, working with partners to share and optimize resources, allocating resources fairly and in accordance with organizational priorities, human resources and performance management systems, the physical environment, and information systems infrastructure.

Monitoring and improving quality and safety: Addresses the organizational systems and processes needed to deliver safe, high quality services and achieve the organization's goals and objectives, including assessing and improving client flow, preparing for disasters and emergencies, and improving patient safety on an ongoing basis.

The approach taken to meet these responsibilities will vary according to the organization's size, structure, and mandate. Some criteria specify that certain responsibilities and activities are carried out in collaboration with the governing body. In organizations where there is no governing body, the organization's leaders take responsibility for these. In some jurisdictions, government may be involved in the operations of the organization and will be responsible for certain activities outlined in these standards. When this is the case, the organization's leaders remain as involved as possible in the process.

As you consider Accreditation Canada's Leadership standards and criteria, you may want to refer to the Leadership Capabilities Framework, LEADS in a Caring Environment. A framework developed to strengthen health care leadership capacity, Leads in a Caring Environment is based on current literature, best practice, and a systematic review of existing leadership competency frameworks. The framework represents the key skills, abilities, behaviours and knowledge required for health leaders at all levels and includes five domains: Lead Self, Engage Others, Achieve Results, Develop Coalitions, and Systems Transformation. Each of these five domains consists of four core measurable leadership capabilities.

All Accreditation Canada standards are developed through a rigorous process that includes a comprehensive literature review, consultation with a standards working group or advisory committee comprised of experts in the field, and evaluation by client organizations and other stakeholders.

If you would like to provide feedback on the standards, please complete the feedback form in this document.

Glossary

Apology: A genuine expression that one is sorry for what has happened. An apology is stated empathically and sincerely, and contains the word 'I am/we are sorry'. An apology is not necessarily an acceptance of responsibility for what has happened, but can acknowledge responsibility when indicated through incident analysis. Some jurisdictions have enacted 'apology legislation' that reduces concerns about the legal implications of making an apology.

Care delivery model: A conceptual model that broadly outlines the way services are delivered. It is based on a thorough assessment of client needs, involving a collaborative approach and stakeholder input, which considers the best use of resources and services that are culturally appropriate. The benefits of using a care delivery model include improving access to services, providing safe, quality care, promoting a client-centred continuum of care, providing access to a balanced range of services, supporting a highly skilled and dedicated workforce, and reducing inequities in health status.

Care plan: May also be known as the service plan, plan of care, or treatment plan. It is developed in collaboration with the client and family and provides details on the client history as well as the plan for services including treatments, interventions, client goals, and anticipated outcomes. The care plan provides a complete picture of the client and their care and includes the clinical care path and information that is important to providing client-centred care (e.g., client wishes, ability/desire to partner in their care, the client's family or support network). The care plan is accessible to the team and used when providing care.

Client: The recipient of care. May also be called a patient, consumer, individual, or resident. Depending on the context, client may also include the client's family and/or support network when desired by the client. Where the organization does not provide services directly to individuals, the client refers to the community or population that is served by the organization.

Client representative or client advisor: Client representatives work with the organization and often individual care teams. They may be involved in planning and service design, recruitment and orientation, working with clients directly, and gathering feedback from clients and team members. Integrating the client perspective into the system enables the organization to adopt a client- and family- centred approach.

Clinical governance: The framework by which the governing body, leaders, and health care providers have responsibility and accountability for the quality of care. Clinical governance processes address individual performance, team performance, and health system and population outcomes.

Co-design: A process that involves the team and the client and family working in collaboration to plan and design services or improve the experience with services. Co-design recognizes that the experience of and input from the client and family is as important as the expertise of the team in understanding and improving a system or process.

Disruptive behavior: Inappropriate conduct, whether in actions or in words, that interferes with or has the potential to interfere with quality healthcare delivery. Examples include inappropriate words, abusive language, shaming, outbursts of anger, and refusal to work cooperatively with others.

Electronic Health Record (EHR): An aggregate, computerized record of a client's health information that is created and gathered cumulatively from all of the client's health care providers. Information from multiple Electronic Medical Records is consolidated into the EHR.

Electronic Medical Record (EMR): A computerized record of a client's health information that is created and managed by care providers in a single organization.

Family: Person or persons who are related in any way (biologically, legally, or emotionally), including immediate relatives and other individuals in the client's support network. Family includes a client's extended family, partners, friends, advocates, guardians, and other individuals. The client defines the makeup of their family, and has the right to include or not include family members in their care, and redefine the makeup of their family over time.

Governance: The system by which authority, decision-making ability, and accountability is exercised in an organization.

Governing body: The body that holds authority, ultimate decision-making ability, and accountability for an organization and its services. This may be a board of directors, a Health Advisory Committee, a Chief and Council, or other body.

Incident analysis: A structured process that occurs following a patient safety incident to identify what happened, how and why it happened, what can be done to reduce the risk of recurrence and make care safer, and what was learned.

Indicator: A single, standardized measure, expressed in quantitative terms, that captures a key

dimension of individual or population health, or health service performance. An indicator may measure available resources, an aspect of a process, or a health or service outcome. Indicators need to have a definition, inclusion and exclusion criteria, and a time period. Indicators are typically expressed as a proportion, which has a numerator and denominator (e.g., percentage of injuries from falls, compliance with standard procedures, team satisfaction). Counts, which do not have a denominator, may also be used (e.g., number of complaints, number of clients harmed as a result of a preventable error, number of policies revised). Tracking indicator data over time identifies successful practices or areas requiring improvement; indicator data is used to inform the development of quality improvement activities. Types of indicators include structure measures, process measures, outcome measures, and balancing measures.

In partnership with the client and family: The team collaborates directly with each individual client and their family to deliver care services. Clients and families are as involved as they wish to be in care delivery.

Interoperable: The ability of two or more systems to exchange information and use the information that has been exchanged.

Medical devices and equipment: An article, instrument, apparatus or machine used for preventing, diagnosing, treating, or alleviating illness or disease; supporting or sustaining life; or disinfecting other medical devices. Examples include blood pressure cuffs, glucose meters, breathalyzers, thermometers, defibrillators, scales, foot care instruments, client lifts, wheelchairs, syringes, and single-use items such as blood glucose test strips.

Medical equipment: A subset of medical devices, considered to be any medical device that requires calibration, maintenance, repair, and user training.

Organization's leaders: Leaders at all levels, including directors, managers, supervisors, clinical leaders, and others who have leadership responsibilities within the organization.

Partner organization: An organization or person who works with another team or organization to address a specific issue by sharing information and/or resources. Partnership can occur at the organization level, team level, or through individual projects or programs.

Patient safety incident: An event or circumstance that could have resulted, or did result, in unnecessary harm to a client. Types of patient safety incidents are:

- Harmful incident: A patient safety incident that resulted in harm to the client. Replaces adverse event and sentinel event.
- No harm incident: A patient safety incident that reached a client but no discernible harm resulted.
- Near miss: A patient safety incident that did not reach the client.

Policy: A document outlining an organization's plan or course of action.

Population: Also known as community. A specific group of people, often living in a defined geographical area who may share common characteristics such as culture, values, and norms. A population may have some awareness of their identity as a group, and share common needs and a commitment to meeting them.

Procedure: A written series of steps for completing a task, often connected to a policy.

Process: A series of steps for completing a task, which are not necessarily documented.

Scope of practice: The procedures, actions, and processes that are permitted for a specific health care provider. In some professions and regions, scope of practice is defined by laws and/or regulations. In these cases, licensing bodies use the scope of practice to determine the education, experience, and competencies that are required for health care providers to receive a license to practice.

Self-efficacy: A person's estimate or judgment of his or her ability to cope with a given situation, or to succeed in completing tasks by attaining specific or general goals. An example of achieving a specific goal includes quitting smoking, whereas achieving a general goal includes continuing to remain at a prescribed weight level.

Stakeholder: A person with an interest in or concern for the organization and its services. Stakeholders may be internal (e.g., staff) or external (e.g., community members).

Talent management: A process that ensures that the organization has adequate and appropriate human resources and leadership capacity-building, including planning for future needs, and encompasses all team members.

Team/Team members: In the context of the Leadership standards, 'the team' represents all individuals working, volunteering, or learning within the organization, including leaders, staff, health care professionals who hold privileges, contracted providers, volunteers, and students.

Timely/regularly: Carried out in consistent time intervals. The organization defines appropriate time intervals for various activities based on best available knowledge and adheres to those schedules.

Transition in care: A set of actions designed to ensure the safe and effective coordination and continuity of care as clients experience a change in health status, care needs, health-care providers or location (within, between, or across settings (as defined by the Registered Nurses' Association of Ontario).

With input from clients and families: Input from clients and families is sought collectively through advisory committees or groups, formal surveys or focus groups, or informal day-to-day feedback. Input can be obtained in a number of ways and at various times and is utilized across the organization.

Legend

Dimensions

Population Focus: Work with my community to anticipate and meet our needs

Accessibility: Give me timely and equitable services

Safety: Keep me safe

Worklife: Take care of those who take care of me

Client-centred Services: Partner with me and my family in our care

Continuity: Coordinate my care across the continuum

Appropriateness: Do the right thing to achieve the best results

Efficiency: Make the best use of resources

Criterion Types

High Priority High priority criteria are criteria related to safety, ethics, risk management, and quality improvement. They are identified in the standards.

Required Organizational Practices Required Organizational Practices (ROPs) are essential practices that an organization must have in place to enhance client safety and minimize risk.

Tests for Compliance

Minor Minor tests for compliance support safety culture and quality improvement, yet require more time to be implemented.

Major Major tests for compliance have an immediate impact on safety.

Performance Measures Performance measures are evidence-based instruments and indicators that are used to measure and evaluate the degree to which an organization has achieved its goals, objectives, and program activities.

CREATING AND SUSTAINING A CARING CULTURE

1.0 Services are delivered and decisions made according to the organization's values and ethics.

Appropriateness

1.1 The organization has a values statement.

Guidelines

Defining organizational values helps to establish parameters for expected behaviour and acceptable relationships with other organizations. Values may include client- and family-centredness, respect, confidentiality, integrity, transparency, honesty and ethical behaviour, equity and fairness, safety, workplace health, and treating people as the organization's greatest asset. Timelines for how often the values statement is defined and updated are established.

The governing body is responsible for defining the organization's values. Depending on the governance model, the organization's leaders support the process by seeking input from team members, clients, families, and the broader community, and by providing advice to the governing body about the values.

In organizations where there is no governing body, the organization's leaders define and update the values statement.

Worklife

1.2 The organization's leaders communicate and demonstrate the values throughout the organization.

Guidelines

The organization's leaders are responsible for disseminating the values throughout the organization. The values should be visible to team members, as well as to clients and families. The values may be communicated orally and in the form of handouts, pamphlets, or posters.

The behaviour of the organization's leaders aligns with the organization's values. The organization's leaders consider the values in decision-making and other processes.

Client-centred Services

1.3 Client- and family-centred care is identified as a guiding principle for the organization.

Guidelines

A guiding principle provides direction to an organization in all circumstances, irrespective of changes in goals, strategic plans, or leadership structure. When making decisions, the organization's leaders consider whether those decisions align with the guiding principles.

A growing body of evidence demonstrates that improving the client experience and developing partnerships with clients and families are linked with improved health outcomes. Each organization needs to consider how this concept is defined and put into practice for their unique mission.

The organization's leaders should model the organization's commitment to client- and family-centred care and client engagement, and update the governing body on client- and family-centred care priorities and initiatives. There are many frameworks for client- and family-centred care. Examples include those from the Institute for Patient and Family Centered Care, Picker Institute, Planetree, and the Institute for Healthcare Improvement (IHI).

Client-centred Services

1.4 Teams are supported in their efforts to partner with clients and families in all aspects of their care.

Guidelines

There are a number of ways to establish meaningful partnerships with clients and families including:
• establishing policies that encourage family presence and ensure that clients have the support they need, when they need it, and from whom is most significant to them (e.g., unrestricted visiting hours)
• including clients and families as participants any time teams are discussing the client's care plan
• partnering with clients and families in processes to improve patient safety and overall quality of care.

Client-centred Services

1.5 Policies addressing the rights and responsibilities of clients are developed and implemented with input from clients and families.

Guidelines

The policies should cover:
• treating clients with respect and dignity
• protecting clients' privacy, confidentiality, safety, and security
• rights and responsibilities of clients in their own service delivery

In some jurisdictions, policies on rights and responsibilities of clients are developed and mandated by an external body such as a ministry of health.

Client-centred Services

1.6 Input is sought from clients and families during the organization's key decision-making processes.

Guidelines

Key decisions are ones that would affect the experience of the client and family and can include a number of things, such as moving or changing a facility, changing services, or adjusting policies. Clients and families can often provide relevant input to such decisions to help maintain a positive client experience.

There are a number of mechanisms through which to gather input from clients and families for decision-making, including committees and councils (e.g., Client and Family Advisory Councils, project-specific committees).

Appropriateness

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1.7 An ethics framework to support ethical practice is developed or adopted, and implemented with input from clients and families.

Guidelines

An ethics framework provides a standardized approach to working through ethics issues and making decisions. The framework can include codes of conduct, guidelines, processes, and values to help guide decision making. Having an ethics framework helps promote ethical behaviour and practices throughout the organization and clarifies ethical issues when they arise. The ethics framework may address issues related to organizational ethics, business ethics, research ethics, clinical ethics, and bioethics, as applicable. Ethical behaviour includes, but is not limited to, maintaining confidentiality; protecting and properly using the organization's assets; and complying with laws, rules, and regulations.

The organization's leaders develop the ethics framework for the organization with support from the governing body, and ensure input from clients, families, and teams.

Worklife

1.8 The ethics framework defines processes for managing ethics issues, dilemmas, and concerns.

Guidelines

The processes defined in the ethics framework encourage anyone involved with the organization (including clients and families) to raise ethics issues and concerns, confidentially if necessary. The process includes criteria to guide discussions and decision making about ethics issues.

Ethics issues may be clinical or non-clinical, and include, but are not limited to, conflict of interest, ethical behaviours, non-compliance with the ethics framework such as breaching confidentiality, ethical implications of resource allocations, the importance of informed consent, and withdrawing life-sustaining treatment.

Worklife

1.9 Accountability for the ethics framework and the processes to address ethics issues is assigned and monitored.

Guidelines

Accountability for the ethics framework and ethics issues means there is an individual, group, or committee responsible for developing, disseminating, and revising the framework. This role is identified in the organizational structure, on the organizational chart, and through defined reporting relationships.

Worklife

1.10 Support is provided to build the capacity of the governing body, leaders, and teams to use the ethics framework.

Guidelines

Capacity to use the ethics framework includes providing support for the governing body, leaders, and teams to develop and enhance their ethics-related knowledge, skills, and expertise. Developing and enhancing ethics-related skills and expertise may be done by providing access to formal education, ensuring ethics frameworks and tools are available, providing forums for case reviews, and disseminating best practices in ethics. Ethics-related capacity may also be built by involving team members, community representatives, and clients and families in ethics-related discussions and decision making.

Worklife

1.11 There is a process for gathering and reviewing information about trends in the organization's ethics issues, challenges, and situations.

Guidelines

In addition to supporting the provision of general ethics-related information, trends in the organization's ethics issues are analyzed to facilitate and inform quality improvement. The ethics framework may be used to gather this information.

Worklife

1.12 Information about trends in ethics issues, challenges, and situations is used to improve the quality of services.

Appropriateness

1.13 The ethics framework includes a process for reviewing the ethical implications of any research activity that the organization leads or participates in.

Guidelines

The process to review ethical implications of research includes criteria for determining when a research project requires ethics approval or when new innovations are considered research, and processes to assess the implications of and approve client participation in research projects.

Research activities should align with the organization's policies and respect laws and regulations of the jurisdiction.

Appropriateness

1.14 Research projects that the organization leads or participates in are reviewed by an objective reviewer or body.

Guidelines

The reviewer or body may be external, e.g., through academic or university linkages; internal, e.g., through a tri-council process; or through a private consultant. The reviewer or body is unbiased, objective, and free from conflict of interest.

The review assesses the merits of the research proposal; the benefits and risks to the participants and the organization; the refusal and exclusion criteria; the process for obtaining informed consent from study participants; the process used to deal with harmful effects that may occur in the course of research; the adequacy of the research design, including its compliance with accepted ethics standards; the qualifications of the project's coordinators; the quality of the background research completed to date, e.g., literature review; the potential impact on the organization's resources; the identification of research sponsors and possible conflicts of interest; and the proposal's compliance with national and provincial or territorial guidelines and protocols, e.g., Research Ethics Boards, tri-council protocols.

Research activities should align with the organization's policies and respect laws and regulations of the jurisdiction.

2.0 A healthy and safe work environment and positive quality of worklife are promoted and supported.

2.1 A healthy and safe work environment is identified as a strategic priority.

Guidelines

The governing body is updated on healthy and safe work environment priorities and progress toward achieving the priorities. Healthy and safe work environment initiatives are aligned with the strategic direction, goals, and objectives.

Initiatives to create a healthy and safe work environment may include role modelling, team-building activities, teaching, coaching, and motivating team members, demonstrating worklife balance, supporting open communication and collaborative decision making, allocating rewards and recognition, and developing and implementing criteria for recognizing and promoting team members.

Worklife

2.2 Support is provided for quality worklife and healthy and safe work environment improvement activities.

Guidelines

Support to improve the quality of worklife and create and maintain a healthy and safe work environment may include educational support for activities such as workshops, conferences, or courses; access to research and best practice information; allocating human or financial resources specifically to organizational quality of worklife improvement; re-organizing existing responsibilities to provide additional time for quality of worklife improvement initiatives; or communicating concrete examples of management commitment to organizational quality of worklife.

Worklife

2.3 The organization's leaders take part in quality of worklife and healthy and safe work environment improvement initiatives.

Guidelines

The organization's leaders should model the organization's commitment to quality worklife and a healthy and safe work environment. The culture of the organization should encourage engagement, where team members contribute to the quality of the work environment and are open to collaboration and innovation.

The organization's leaders demonstrate support for and promote a positive worklife through all levels of the organization. They may be involved by supporting an engagement process to determine which initiatives are meaningful to teams; leading improvement projects or initiatives; coaching and mentoring; or identifying and supporting quality of worklife and healthy and safe work environment champions.

Worklife

2.4 A code of conduct that applies to all those working in the organization is developed and implemented.

Guidelines

A code of conduct outlines the behaviors expected and behaviors that are not acceptable in the organization. All team members should be held to the same expectations regarding acceptable behavior. The code of conduct should align with the organization's values and ethics framework.

When developing the code of conduct, input should be sought from those affected by the code, in order to create buy-in and support for the code.

Worklife

2.5 A policy regarding reporting, investigating, and resolving behavior that contravenes the code of conduct is developed and implemented.


Worklife

2.6 Strategies are developed to help team members to manage their health.

Guidelines

Factors such as organizational culture, work demands, scheduling, human and other resources, and outside demands all have an impact on workplace health. Healthy workplace strategies address all aspects of health including physical, emotional, and mental health and may include education about health and determinants of health; programs to help manage stress, reduce weight, and quit smoking; initiatives to encourage healthy lifestyles; flexible work time; Employee Assistance Programs (EAP) or other counselling services to help individuals to manage work and outside demands; or seeking input on scheduling and work design.


Worklife

2.7 There is a process in place to support leaders throughout the organization to develop their capabilities to promote a safe and healthy work environment.

Guidelines

Helping leaders throughout the organization to understand, experience, and support quality worklife may include developing clear guidelines on span of control, effective delegation, and links between authority and accountability to make workload manageable; communicating expectations about worklife quality; mentoring new leaders; developing knowledge related to factors influencing worklife quality and their impact on the work environment; implementing human resource practices and best practice leadership development guidelines (e.g., the Engage Others domain in the LEADS in a Caring Environment Leadership Capabilities Framework, which underscores the importance of fostering the development of others and contributing to the creation of a healthy work environment); and creating an organizational culture that supports the development of healthy leadership styles.


Worklife

2.8 Continuing professional development and learning is supported.

Guidelines

Supporting continuing professional development and learning may include providing resources for courses or conferences or innovative and new ways to access learning and resources so that team members can keep up with advancements in their field and develop skills.

Information on continuous professional development and learning can be found in the resource document LEADS in a Caring Environment Leadership Capabilities Framework, specifically the Lead Self and Engage Others domains. The Lead Self domain addresses how to engage in lifelong learning and self-development through exercising self-awareness and self-management, developing oneself, and demonstrating character. The Engage Others domain provides guidance and information on supporting the development of team members by supporting and challenging them to achieve their professional and personal goals and creating a healthy organization where they have meaningful opportunities to contribute and the resources and capabilities to fulfill their responsibilities.

Worklife

2.9 Workplace health and safety policies that comply with relevant legislation are developed and implemented.

Guidelines

Relevant legislation includes occupational health and safety legislation and workplace safety and insurance legislation.

A comprehensive approach to workplace health and safety can include identifying and assessing risks to team members and clients; creating and maintaining a disability management system; identifying roles in promoting and ensuring safety; conducting regular safety audits; or providing education about safe work practices and emergency prevention and preparedness.

Worklife

2.10 An immunization policy and associated procedures, which include recommending specific immunizations for team members, are developed.

Guidelines

The policy and procedures identify the required and recommended immunization for team members according to their duties, level of interaction with clients and families, and risk to themselves and others.

Immunizations required for team members vary depending on the type of organization and the clients it serves (e.g., requiring and recommending specific immunizations in children's hospitals).

In some jurisdictions, immunization requirements may be the mandate of public health.

Safety

2.11 Team members' fatigue and stress levels are monitored and work is done to reduce safety risks associated with fatigue and stress.

Guidelines

Industries such as the military and aviation recognize that stress and fatigue have an impact on safety. Stress and fatigue can result from workload, restricted autonomy or decision-making power, scheduling and staffing issues, or environmental distractions such as noise.

Stress and fatigue may be monitored by tracking absenteeism or how often extended hours and double shifts are worked. Information can also be collected through the results of team satisfaction/experience surveys.

The Productive Ward: Releasing Time to Care improvement modules enable and empower team members to optimize systems and processes and minimize inefficiencies in their work environment to increase the amount of time spent on direct patient care.

Resources to help manage stress and mental health in the workplace:

• WHO's “Human Factors in Patient Safety: Review of Topics and Tools”

• Mental Health Commission of Canada's “Psychological Health and Safety: An Action Guide for Employers”.

Safety

2.12 REQUIRED ORGANIZATIONAL PRACTICE: A documented and coordinated approach to prevent workplace violence is implemented.

Guidelines

Workplace violence is more common in health care settings than in many other workplaces, with one-quarter of all incidents of workplace violence occurring at health services organizations. It is an issue that affects staff and health providers across the health care continuum.

Accreditation Canada has adopted the modified International Labour Organization definition of workplace violence, as follows: “Incidents in which a person is threatened, abused or assaulted in circumstances related to their work, including all forms of harassment, bullying, intimidation, physical threats, or assaults, robbery or other intrusive behaviours. These behaviours could originate from customers or co-workers, at any level of the organization.”

The Registered Nurses Association of Ontario describes four classifications of workplace violence:
Type I (Criminal Intent): Perpetrator has no relationship to the workplace.
Type II (Client or Customer): Perpetrator is a client, visitor, or family member of a client at the workplace who becomes violent toward a worker or another client.
Type III (Worker-to-worker): Perpetrator is an employee or past employee of the workplace.
Type IV (Personal Relationship): Perpetrator has a relationship with an employee (e.g., domestic violence in the workplace).

A strategy to prevent workplace violence should be in compliance with applicable provincial or territorial legislation, and is an important step to respond to the growing concern about violence in health care workplaces.

Test(s) for Compliance

Major 2.12.1 There is a written workplace violence prevention policy.

Major	2.12.2	The policy is developed in consultation with team members and volunteers as appropriate.
Major	2.12.3	The policy names the individual(s) or position responsible for implementing and monitoring adherence to the policy.
Major	2.12.4	Risk assessments are conducted to ascertain the risk of workplace violence.
Minor	2.12.5	There are procedures for team members to confidentially report incidents of workplace violence.
Major	2.12.6	There are procedures to investigate and respond to incidents of workplace violence.
Minor	2.12.7	The organization's leaders review quarterly reports of incidents of workplace violence and use this information to improve safety, reduce incidents of violence, and improve the workplace violence prevention policy.
Minor	2.12.8	Information and training is provided to team members on the prevention of workplace violence.

Worklife

2.13 A process is developed for team members to confidentially bring forward complaints, concerns, and grievances.

Guidelines

The organization's culture supports open discussion and ability to raise issues without fear of repercussions.

Appropriateness

2.14 Process and outcome measures related to worklife and the work environment are identified and monitored.

Guidelines

Process measures may include rates of participation in healthy workplace activities; the number and type of complaints, concerns, and grievances; and participation rates in professional development. Outcome measures include team satisfaction; sick time or absenteeism; vacancy and retention rates; and amount of overtime. The Quality Worklife/Quality Health Care Collaborative has identified a core list of worklife indicators that are available on their website.

Worklife

2.15 ACCREDITATION CANADA REQUIRED INSTRUMENT: The quality of the organization's worklife culture is monitored using the Worklife Pulse Tool.

Guidelines

The quality of worklife and team attitudes to and perceptions of the workplace is evaluated. Results can be used to identify areas that are already strong as well as areas that require improvement. Results also provide a baseline against which future assessments can be compared.

Instrument Information

2.15.1 The Worklife Pulse Tool (or a substitute tool approved by Accreditation Canada) is administered at least once per accreditation cycle. Organizations in the joint CQA/Accreditation Canada Program administer the « sondage sur la mobilisation du personnel » and the Worklife Pulse Tool is optional.

2.15.2 Action has been taken on the most recent worklife tool results.

3.0 A quality improvement culture is promoted throughout the organization.

Appropriateness

3.1 Quality improvement is identified as a strategic priority.

Guidelines

The organization's leaders report to the governing body on quality improvement priorities, and update the governing body on progress toward achieving the priorities. Quality improvement initiatives are aligned with the strategic direction, goals, and objectives, and the governing body provides oversight and monitors the achievement of the quality improvement initiatives.

In organizations where there is no governing body, the organization's leaders take responsibility for identifying quality improvement priorities.

Appropriateness

3.2 Resources are allocated to support quality improvement activities.

Guidelines

Resources to support quality improvement activities may include allocating human or financial resources specifically to quality improvement, or re-organizing existing responsibilities so that teams have additional time for quality improvement initiatives.

Worklife

3.3 Teams, clients, and families are supported to develop the knowledge and skills necessary to be involved in quality improvement activities.

Guidelines

The organization's leaders should act as quality improvement champions and facilitate creativity and innovation by encouraging and building the capacity of team members and clients and families to think proactively about quality improvement.

Educational support for quality or process improvement may include workshops, conferences, courses, and access to research and best practice information. Other supports may include providing access to education or information sessions on improvement methodology and theory and how to undertake quality improvement projects through initiatives and cycles.

Client-centred Services

3.4 There are clear, documented processes shared with clients and families about how to file a complaint about the organization or their care or to report a violation of their rights.

Appropriateness

3.5 Opportunities are provided for leaders throughout the organization to participate in collaborative quality improvement initiatives.

Guidelines

Opportunities for participation and collaboration in quality improvement initiatives may include providing opportunities to undertake or lead quality improvement projects with mentors, or providing opportunities to lead projects that are part of larger projects or initiatives.

Appropriateness

3.6 There are regular dialogues between the organization's leaders and clients and families to solicit and use client and family perspectives and knowledge on opportunities for improvement.

Guidelines

Clients and families offer a unique perspective on quality improvement opportunities for organizations. Using client and family feedback to make improvements creates a responsive system and demonstrates that the organization values the opinion of clients and their families.

Clients and families can be engaged to identify opportunities for improvement and to design solutions by:
- holding focus groups or interviews
- setting up feedback kiosks in the organization
- speaking to clients at the point-of-care

A variety of methods should be used to engage clients and families in quality improvement processes in order to get the most feedback possible.

Worklife

3.7 The organization's leaders are involved in leading quality improvement initiatives.

Guidelines

The organization's leaders act as quality improvement champions by sponsoring, supporting and participating in quality improvement initiatives to promote a culture of quality improvement throughout the organization. They may be involved in initiating or leading specific quality improvement projects or initiatives; coaching and mentoring team members, clients, and families about ongoing quality improvement; identifying quality improvement champions; or facilitating changes throughout the organization based on quality improvement project results.

Information on the role of leadership in quality improvement can be found in the resource document LEADS in a Caring Environment Leadership Capabilities Framework specifically the Systems Transformation and Achieve Results domains, which address how to lead change and approaches for overcoming challenges in implementing change.

Appropriateness

3.8 The spread and sustainability of quality improvement results is promoted and supported.

Guidelines

In addition to leading quality improvement initiatives at the service level, it is important for leaders throughout the organization to consider how improvements in their team, unit, or program may affect other areas of the health organization or system. Considerations should include the implications or impacts to other areas and methods for spreading the improvements or changes. Ideas, strategies, resources, and information to support the spread and sustainability of improvements should be provided.

Appropriateness

3.9 The organization's leaders promote learning from quality improvement results, and making decisions informed by research and evidence, client experience, and ongoing quality improvement.

Guidelines

Learning from results includes learning from positive as well as negative or surprising results. This process may include providing time to reflect on results, ensuring support and teaching skills needed to learn from results, providing mechanisms for collective feedback and reflection such as briefings, and balancing between learning from results and focusing on end results.

Appropriateness

3.10 The organization's leaders promote and support the consistent use of standardized processes, decision-support tools, or best practice guidelines to reduce variation in and between services, where appropriate.

Guidelines

While recognizing that each client may present with unpredictable and unique needs, reducing inappropriate variation in services and care through the use of standardized processes, protocols, or best practice guidelines reduces risks to patient safety.

Worklife

3.11 Team members, clients, and families who participate in quality improvement initiatives are recognized for their work.

Guidelines

Recognition may include awards, announcements in newsletters or at organization meetings, or other rewards. Recognition may be individual, team, or program-based.

PLANNING AND DESIGNING SERVICES

4.0 Services are planned and designed to meet the needs of the community.

Appropriateness

4.1 There is a process to develop or update the mission statement with input from team members, clients, families, and key stakeholders.

Guidelines

The mission statement, sometimes referred to as the statement of purpose, describes the organization's purpose and mandate, the populations it serves, and its scope of services. The mission statement is easy to understand and simply written.

How the organization's leaders participate in the process to develop or update the mission statement may vary. The governing body requires input from within the organization and its stakeholders, including teams, clients, and families. It is often through the CEO or executive director that input is gathered and brought back to the governing body. In the case of public organizations, gathering input may include consultation with the public and community.

In organizations where there is no governing body, the organization's leaders take responsibility for developing the mission. In some jurisdictions, this process may be the responsibility of government.

Appropriateness

4.2 The organization has a vision and strategic plan.

Guidelines

The frequency and formality of the strategic planning process may differ according to the size and type of the organization. The strategic planning process is used to identify the organization's long-term vision and strategy to achieve the vision. The organization's leaders should partner with a broad network of stakeholders in the strategic planning process, including team members, clients, and families.

In some jurisdictions, this process may be the responsibility of government.

Population Focus

4.3 Services are planned with input from clients, families, and the broader community.

Guidelines

Input may be sought in a variety of formal or informal ways, e.g., focus groups, town hall meetings, feedback or complaint mechanisms, client and family advisory councils, and other community engagement activities and consultation processes.

Appropriateness

4.4 When developing the vision and strategic plan, the needs of clients, families, and the broader community, as well as priorities set by government and other stakeholders, are considered and incorporated where possible.

Guidelines

In some cases, particularly for publicly-funded organizations, the priorities may be set by government through legislation or through performance or accountability agreements.

In the case of private organizations, emphasis may be placed on aligning the vision and strategic plan with the priorities of stakeholders, including shareholders.

Appropriateness

4.5 When developing the vision and strategic plan, risks and opportunities for the organization are assessed.

Guidelines

The environment and any anticipated changes that may be a risk or present an opportunity for the organization are understood and considered. These risks and opportunities are assessed and strategies to address them are incorporated into the strategic plan.

In some jurisdictions this process may be the responsibility of government.

Appropriateness

4.6 The strategic plan identifies goals and objectives that are consistent with the mission and values and have measurable outcomes.

Guidelines

The goals and objectives reflect input from within the organization, the community's changing needs and health status, priorities set by government or other stakeholders, and risks and opportunities for the organization. The goals and objectives contribute to improved service results and organizational performance.

Appropriateness

4.7 An ongoing environmental scan is conducted to identify changes and new challenges, and the strategic plan, goals, and objectives are adjusted as needed, with oversight and guidance from the governing body.

Guidelines

In some jurisdictions this process may be the responsibility of government, in which case, the organization's leaders should be aware of the content of the environmental scan and use the results for service planning.

Population Focus

4.8 The organization's mission, vision, and values are shared with team members, clients and families, and the community.

Guidelines

Sharing the mission, vision, and values may include making them publicly accessible by, for example, posting them in the organization's reception or lobby, or on the organization's website.

Appropriateness

4.9 The strategic goals and objectives are communicated to team members throughout the organization, and to clients and families.

Appropriateness

4.10 Goals and objectives at the team, unit, or program level align with the strategic plan.

Appropriateness

4.11 The organization's progress toward achieving the strategic goals and objectives is reported to internal and external stakeholders and the governing body where applicable.

Appropriateness

4.12 Policies and procedures for all of the organization's primary functions, operations, and systems are documented, authorized, implemented, and up to date.

Guidelines

Primary functions vary depending on the organization's scope of services. It is up to the organization's leaders to identify the primary functions, operations, and systems. Policies and procedures include standard operating procedures and organizational policies, procedures, and plans.

5.0 The changing needs and health status of the community served are understood.

Population Focus

5.1 Information about the community's health status, capacities, and health care needs is collected or available to the organization from other sources.

Guidelines

This information may be called a health or community needs assessment, or a community profile. It includes trends and changes in the environment, including demographic information, e.g., age, cultural diversity, literacy, language; the impact of the determinants of health, e.g., housing conditions, and socioeconomic status; the prevalence of risk factors that may lead to health issues, e.g. smoking rates, rates of overweight/obesity; and feedback from clients and the community about their health care needs.

If it is not within the organization's mandate to collect information or conduct the community needs assessment, the organization accesses and uses information that is available. Information may be obtained from a variety of sources, e.g., Canadian Institute for Health Information, Public Health Agency of Canada, and census data.

Population Focus

5.2 Information about the community is used to assist in planning the organization's scope of services.

Guidelines

As new information becomes available or as the community's needs evolve, the organization adapts to meet those needs.

If the organization does not determine its scope of services (e.g., the scope of services is mandated by government or through legislation), information about the community is used to understand how the organization's mandate and services contribute to meeting the community's needs, and to identify service gaps.

Population Focus

5.3 Information about the community is maintained in a format that is up-to-date and easy to understand.

Guidelines

The information about the community is clear and easy for teams to understand.

In some jurisdictions this process may be the responsibility of government.

Population Focus

5.4 Information about the community is shared with the governing body, teams, and stakeholders, including other organizations, clients, and families.

Guidelines

The organization determines how information about the community is disseminated, including the format and the degree of detail. It also identifies any restrictions such as privacy legislation.

In some jurisdictions this process may be the responsibility of government.

6.0 Operational plans are developed and implemented to achieve the strategic plan, goals, and objectives.

Appropriateness

! 6.1 Annual operational plans are developed to support the achievement of the strategic plan, goals, and objectives, and to guide day-to-day operations.

Worklife

6.2 When developing the operational plans, input is sought from team members, clients and families, and other stakeholders, and the plans are communicated throughout the organization.

Efficiency

6.3 The operational plans identify the resources, systems, and infrastructure needed to deliver services and achieve the strategic plan, goals and objectives.

Guidelines

The operational plans take into account the organization's human resources, information management, and infrastructure capacities and requirements.

Depending on the size of the organization, these elements may be addressed in one plan such as a business plan. Alternatively, the organization may develop separate plans to address each element. If separate plans are developed, there is a process to ensure that priorities and resource allocations among the various plans are aligned.

Appropriateness

6.4 The organization's structures and services or program areas are designed, implemented, and adapted as required to support service delivery and achievement of the operational plans.

Guidelines

Structures include reporting relationships as defined on the organizational chart and in practice, including support services such as administration, finance, or accounting. Reporting relationships need to balance professional autonomy with the organization's leaders' responsibility for overall coordination and control. This may be done by distinguishing clinical leadership, e.g., Medical Affairs, Chief Medical Officer or Chief Nursing Officer, from operational leadership, e.g., Chief Operating Officer.

The organization's structures, services, or program areas are adapted to accommodate changes and new challenges such as emerging health problems or needs, knowledge and technological advances, or the need for adjustments to the strategic direction, goals, and objectives.

Appropriateness

6.5 Formal strategies or processes are used to manage change.

Guidelines

Organizational approaches to managing change differ according to the type and scope of the change, and its impact on the organization, teams, clients, families, and the community. Change may be operational, financial, or departmental.

A formal change management process includes identifying a clear vision for change and communicating the vision to team members; creating an operating plan to implement the change; defining roles and responsibilities for managing change; allocating financial and human resources to support the change process; and monitoring and evaluating the results when the change management process is implemented.

Appropriateness

6.6 Management systems and tools are used to monitor and report on the implementation of operational plans.

Guidelines

Management systems and tools are selected to support coordination, assessment, and evaluation of organizational processes and services, including decision making processes. They may include report cards, e.g., balanced scorecards; ensuring process and outcomes measures are tied directly to strategic goals and objectives; financial reporting tools such as forecast and actual budgets; and project management tools.

7.0 The organization's leaders collaborate with a broad network of stakeholders.

Population Focus

7.1 The organization's leaders work with the governing body to identify and collaborate with external stakeholders.

Guidelines

External stakeholders may include governments or other funding authorities, partner or similar organizations, interest or volunteer groups, professional bodies and associations, contractors or contracting agencies, marginalized populations, and the community as a whole.

This is a collaborative process between the organization and the governing body, in which the organization's leaders play an important role in advising the governing body on who its stakeholders are and how to anticipate and respond to stakeholders' interests.

If the organization does not have a governing body, the organization's leaders are responsible for identifying and interacting with external stakeholders on the organization's behalf.

Information on collaborating with external stakeholders strategically can be found in the resource document LEADS in a Caring Environment Leadership Capabilities Framework, specifically the Develop Coalitions domain, which addresses how to proactively determine the appropriate situations in which to build meaningful partnerships and networks to achieve positive results.

Appropriateness

7.2 The organization's leaders promote the organization and demonstrate the value of its services to stakeholders and the community.

Guidelines

Advocacy is a shared responsibility among the governing body, the organization's leaders, and other team members.

The organization's leaders play an important role in ensuring that the community is aware of the services delivered by the organization and the organization's role in the community. By advocating or encouraging support for the organization, the organization's leaders can increase the profile of and bring recognition to the organization.

In consultation with the governing body, the organization's leaders determine the scope of advocacy activities. Activities may include participating in community events, e.g., fundraisers, campaigns; supporting healthy public policy to address the determinants of health, e.g., smoking bans in public places, environmental health legislation; communicating the results of quality improvement initiatives; demonstrating performance in key areas; and raising community awareness about issues.

Population Focus

7.3 Partnerships are developed with other organizations in the community to efficiently and effectively deliver and coordinate services.

Guidelines

Meeting the full range of the community's service needs is beyond the capabilities of any one organization. The organization's leaders identify partnerships needed to provide access across the continuum of service, and looks for ways to reduce duplication and share resources with other organizations.

For organizations with more than one service or setting, partnerships identified by the governing body and the organization's leaders are used as a starting point for each program or service area to develop their own partnerships to coordinate services and make it easier for clients to access services. Community partnerships may be formed with, for example, organizations providing acute care, primary care, community-based programs, public health services, outpatient services, long-term care, home care, or counselling services.

Population Focus

7.4 The organization's leaders support and participate in ongoing community initiatives to promote health and prevent disease.

Guidelines

The organization's level and type of involvement will vary according to its size, mandate, and whether it is public or private. It may participate in fundraising initiatives, or by advocating for healthy public policy affecting determinants of health. The organization may also be involved through initiatives supported by individual programs or service areas, e.g., supporting healthy eating and exercise initiatives for diabetic populations, or promoting community awareness of conditions such as Alzheimer's disease or stroke, although it is not necessary that every team or service area have its own community development initiatives.

Population Focus

7.5 There is an organization communication plan that addresses disseminating information to and receiving information from internal and external stakeholders.

Guidelines

The communication plan is used to develop open, two-way communication with stakeholders. It identifies different communication mechanisms that may be available to target different groups, as well as what information is shared, how it is shared and with whom, and the goals and objectives of sharing information with stakeholders and the community. For public organizations, it also addresses dissemination of information to government.

The organization's internal stakeholders may include team members; foundations; unions; potential and actual clients and families, including family councils or advisory committees; and shareholders. The organization understands who its internal stakeholders are (e.g., both individuals and groups), their needs and interests, and their roles in supporting and implementing strategic and operational decisions.

In organizations with a governing body, the governing body oversees the development of the communication plan and the organization's leaders implement the communication plan.

Appropriateness

7.6 Input is sought from stakeholders on a regular basis to evaluate the effectiveness of their relationships with the organization.

Guidelines

The frequency of evaluating the effectiveness of relationships with stakeholders should be established and followed by the organization's leaders. They may seek input in a variety of formal or informal ways, e.g. focus groups, feedback or complaint mechanisms, community engagement activities and consultation, or union or other deliberations.

ALLOCATING RESOURCES AND BUILDING INFRASTRUCTURE

8.0 The organization's financial resources are allocated and managed to maximize efficiency and meet the service needs of the community.


Efficiency

8.1 Resource allocation is a part of the regular planning cycle for the organization.

Guidelines

The organization's leaders are responsible for making resource allocation recommendations to the governing body. The governing body assumes responsibility for risk identification and assessment to guide resource allocation, and oversees senior leaders' resource allocation decisions.

In organizations where there is no governing body, leaders take responsibility for resource allocation decisions, including risk identification and assessment. In some jurisdictions, this process may be the responsibility of government.


Efficiency

8.2 Annual operating and capital budgets are prepared according to the organization's financial policies and procedures.

Guidelines

The financial policies include generally accepted accounting principles (GAAP), and board or government guidelines. Operating and capital budgets demonstrate that resources are appropriately allocated throughout the organization. The operating budget tracks the organization's profits and losses, as well as the costs of services.

When preparing the annual operating and capital budgets, the organization's mission, vision, and strategic goals and objectives are considered, and input is sought from team members.

Appropriateness

8.3 There are opportunities for leaders throughout the organization to receive education on how to manage and monitor their budgets.

Population Focus

8.4 Input is gathered from external and internal stakeholders when making resource allocation decisions.

Guidelines

Input may include information gathered about the community, e.g., the community needs assessment; advice from community partners about opportunities to share resources to maximize efficiency; priorities as identified by clients and families and the community; resource allocation dictated by provincial or territorial governments, donors or foundations; and resource requests from internal committees, e.g., capital planning.

Appropriateness

8.5 Set criteria are used to guide resource allocation decisions.

Guidelines

Resources are distributed according to set criteria that address populations, geographic regions served, and the continuum of service. The criteria used to guide resource allocation decisions will differ according to the size, mandate, and scope of the organization, but, in general, they consider the community's needs and priorities; funding available from public and private sources; ethical guidelines and processes; the organization's mission, vision, values, and strategic goals and objectives; client- and family-centred care objectives, and data and evidence, e.g., cost-effectiveness analyses.

In some publicly funded organizations, the resource allocation process may be the responsibility of government. In these cases, the organization's leaders understand the process by which resources are allocated and the criteria that guide those decisions.

Appropriateness

8.6 There is a process to have annual operating and capital budgets approved by the governing body.

Guidelines

In organizations where there is no governing body, the organization's leaders take responsibility for developing and approving the budgets. In some jurisdictions, this process may be the responsibility of government.

Efficiency

8.7 There is a process to move resources to where they are needed most within and across operational and service or program areas.

Guidelines

The process for resource allocation is flexible enough to respond to changing needs and priorities. This may include contingency plans to respond to changes in a timely manner.

In organizations where the resource allocation process is the responsibility of government, the organization's leaders are involved in identifying changing needs and priorities, appealing for additional resources, and responding accordingly.

Efficiency

8.8 The impact of resource allocation decisions is regularly analyzed.

Guidelines

The frequency of analyzing the impact of resource allocation decisions is established and followed by the organization's leaders. They analyze how resource allocation decisions affect quality of care, the ability to meet the community's needs, worklife culture, team member health, and the achievement of the strategic goals and objectives.

When moving resources from one service area to another, the organization's leaders anticipate the impact and plan accordingly.

Efficiency

8.9 Budgets are monitored and regular reports are generated on the organization's financial performance.

Guidelines

How frequently the budget must be monitored and reports generated is established by the organization, and evidence of that schedule is available. Reports and other information about financial performance, e.g., potential risks to the organization's financial position, are provided to the governing body, where one exists.

In organizations where there is no governing body, financial performance reports are provided to the owner, shareholders, or other individuals or groups responsible for monitoring financial performance.

Efficiency

8.10 Reports on financial performance include an analysis of the utilization of resources and outline opportunities to improve the effective and efficient use of resources.

Guidelines

Resource utilization analysis is used to identify and address opportunities for efficiencies. There are several techniques to review the utilization of resources. The organization may complete a formal utilization review, e.g., retrospective review of the use of resources overall or by a specific program or service areas; case costing by diagnosis; or comparisons of actual to forecast budgets and an analysis of the drivers affecting gaps.

Appropriateness

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8.11 The organization's leaders verify that the organization meets legal requirements for managing financial resources and financial reporting, e.g., audit, running a deficit.

Guidelines

Legal requirements for financial management and reporting will vary by the size of the organization and whether it is public or private.

9.0 The physical environment is safe.

Safety

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9.1 The physical space meets applicable laws, regulations, and codes.

Guidelines

Considerations include maintaining heating, ventilation, and air-conditioning systems that control temperature, humidity, odours, and availability of fresh air; preventing exposure to second-hand smoke; ensuring the physical infrastructure, e.g. windows, roofs, and elevators, are in working order and meet applicable codes; having suitable furniture and equipment that considers ergonomics and addresses the needs of clients and team members with special needs; and security systems to protect teams and clients.

Many health care organizations face constraints related to older buildings and physical infrastructure. Regular inspections should be conducted to ensure that physical and environmental conditions are compliant with legislative standards to protect the health, safety, and security of teams and clients.

In cases where services are delivered in clients' homes, there are mechanisms to assess the safety of the home.

Client-centred Services

9.2 There are mechanisms to gather input from clients and families in co-designing new space and determining optimal use of current space to best support comfort and recovery.

Safety

9.3 Client and team health and safety are protected at all times and particularly during periods of construction or renovation.

Guidelines

During periods of construction or renovation, client and team safety considerations may include infection prevention and control; restricted access to areas under construction; control of dangerous substances or equipment; and isolation of construction and renovation activities to limit the impact on service delivery.

Appropriateness

9.4 There is a formal and open process for selecting and buying medical devices and equipment, and for selecting qualified suppliers.

Guidelines

The process for selecting and buying medical devices and equipment takes into account standardization of equipment throughout the organization; information from teams, clients, and families; the level and type of services provided, including clients' functional abilities; the knowledge and skills needed for use; potential risks or impacts on infection control including reprocessing, occupational health and safety, and waste creation and disposal; the latest research and evidence and advances in technology; and whether the benefits are worth the costs.

Organizations may want to consult the following references for additional information: “Medical Device Technology Management” (Section 3) in Clinical Engineering Standards of Practice for Canada (Rev. September 2007) by the Canadian Medical and Biological Engineering Society (CMBES); and “Processus de gestion et de suivi des dispositifs médicaux: Acquisition” (BPO-06-2) in Guide des bonnes pratiques biomédicales en établissement de santé – adaptation québécoise (June 2005) by l'Association des physiciens et ingénieurs biomédicaux du Québec (APIBQ) and l'Association des technicien (ne)s en génie biomédical (ATGBM).

In organizations where medical devices and equipment are outsourced, e.g., loaned, consigned, or leased, the organization applies the same selection process as for medical devices and equipment that are purchased, and follows the same process to select suppliers.

Safety

9.5 There is a process to provide education for teams on the safe operation of medical devices and equipment.

Appropriateness

9.6 There is a procedure or policy to ensure that team members using specialized medical devices and equipment are authorized and trained to do so.

Guidelines

The process or policy may include maintaining a list of authorized and trained users for specialized medical devices and equipment or having access codes or numbers that must be entered before the devices and equipment are used.

Appropriateness

9.7 Plans or processes for maintaining, upgrading, and replacing medical devices and equipment are followed.

Guidelines

Plans address maintenance schedules and documentation processes for service checks and routine and preventive maintenance; life cycle management; safe, secure, and efficient storage; and emergency servicing or repair.

Organizations may want to consult the following references for additional information: “Medical Device Technology Management” (Section 3) and “Technology Planning and Evaluation” (Section 4) in Clinical Engineering Standards of Practice for Canada (Rev. September 2007) by the Canadian Medical and Biological Engineering Society (CMBES); and “Processus de gestion et de suivi des dispositifs médicaux: Planification” (BPO-06-1) and “Processus de gestion et de suivi des dispositifs médicaux: Maîtrise et maintien en exploitation” (BPO-06-4) in Guide des bonnes pratiques biomédicales en établissement de santé – adaptation québécoise (June 2005) by l'Association des physiciens et ingénieurs biomédicaux du Québec (APIBQ) and l'Association des technicien(ne)s en génie biomédical (ATGBM).

Safety

9.8 REQUIRED ORGANIZATIONAL PRACTICE: A preventive maintenance program for medical devices, medical equipment, and medical technology is implemented.

Guidelines

An effective preventive maintenance program helps ensure medical devices, medical equipment, and medical technology are safe and functional. It also helps identify and address potential problems with medical devices, medical equipment, or medical technology that may result in injury to team members or clients.

Test(s) for Compliance

Major	9.8.1	There is a preventive maintenance program for all medical devices, medical equipment, and medical technology.
Major	9.8.2	There are documented preventive maintenance reports.
Minor	9.8.3	There is a process to evaluate the effectiveness of the preventive maintenance program.
Major	9.8.4	There is documented follow up related to investigating incidents and problems involving medical devices, equipment, and technology.


Safety

9.9 The organization's leaders develop and follow policies and procedures to manage patient safety incidents involving medical devices, equipment, and technology, including cases involving misuse.

Guidelines

The policy includes a requirement for follow-up on medical equipment or devices involved in a patient safety incident.

Organizations may want to consult the following references for additional information: the Incident Investigation standard of “Patient Safety and Risk Management” (Section 5) in Clinical Engineering Standards of Practice for Canada (Rev. September 2007) by the Canadian Medical and Biological Engineering Society (CMBES); and “Processus de gestion des risques et de la qualité: processus de gestion des risques” (BPO-02-1) in Guide des bonnes pratiques biomédicales en établissement de santé – adaptation québécoise (June 2005) by l'Association des physiciens et ingénieurs biomédicaux du Québec (APIBQ) and l'Association des technicien(ne)s en génie biomédical (ATGBM).

Safety

9.10 Steps, including introducing back-up systems, are taken to reduce the impact of utilities failures on client and team health and safety.

Guidelines

Utilities include electricity, potable water, sterile water, fuel, medical gases, and vacuum systems.

In community-based settings such as clients' homes, the organization's leaders may arrange for back-up systems if the power goes out, e.g., batteries or mini-generators for home ventilator equipment.

Population Focus

9.11 Initiatives are undertaken to minimize the impact of the organization's operations on the environment.

Guidelines

Initiatives may include increasing opportunities to reduce, reuse, and recycle; conserving resources such as water and energy; using products and promoting practices that are environmentally friendly, e.g., phosphate-free soap or environmentally friendly food preparation; controlling emissions; properly disposing of substances that are dangerous to the environment; participating in community programs or events to improve the environment, e.g., “clean up” days; partnering with local environmental management agencies; or beautifying and maintaining its outdoor surroundings.

10.0 The organization invests in its people and supports their professional development.

Worklife

10.1 Recruitment and selection of team members is conducted in an equitable manner according to individual qualifications and their capability to contribute to the organization's values, goals, and objectives.

Worklife

10.2 Retention strategies are implemented.

Guidelines

Retention is closely related to the work environment and workplace health. As such, many retention strategies are similar to strategies to promote a healthy and safe work environment and workplace health, such as introducing specific strategies for workplace flexibility, e.g., flexible work hours; recognizing and rewarding contributions; providing child care services; creating opportunities for mentoring, promotions, transfers, or job shadowing; offering professional development including the opportunity to develop leadership skills; and monitoring stress and fatigue to minimize gaps in service and risk of burnout.

Other strategies may include reviewing compensation to make sure it is fair and equitable.

Retention strategies depend on the organization's size; types of team members; and other factors such as geography.

Worklife

10.3 The staffing process used is evidence-based and makes appropriate use of individual skills, education, and knowledge.

Guidelines

The staffing process is based on objective criteria such as client health needs, client acuity, service complexity, and organizational resources.

The staffing process includes evaluating staffing effectiveness on a regular basis, and identifying ways to rectify the situation when staffing levels fall below a safe level.

The staffing process may be influenced or impacted by collective agreements, e.g., seniority provisions.

Client-centred Services

10.4 Education and training are provided throughout the organization to promote and enhance a culture of client- and family-centred care.

Guidelines

Training and education programs are established to orient teams to the strategy, goals, behaviours, and actions that enable a culture of client- and family-centred care. Teams are provided with training on the skills to engage in successful partnerships and communicate effectively with clients and families.

Worklife

10.5 There is a talent management plan that includes strategies for developing leadership capacity and capabilities within the organization.

Guidelines

The talent management plan should address succession planning, human resources development planning, and plans for building leadership capacity throughout the organization. This contributes to a healthy work environment by empowering and engaging team members to pursue leadership roles and positions.

Leadership development should be continuous and ongoing, fostered by a coaching or learning culture.

Information on fostering the development of leaders can be found in the resource document LEADS in a Caring Environment Leadership Capabilities Framework, specifically the Lead Self and Engage Others domains, which address how to build capabilities to effectively carry out leadership behaviours and processes. Strategies for developing leaders throughout the organization may include leadership workshops, coaching, mentoring, simulation activities, and leadership exchange programs. An important aspect of leadership is the development of motivational skills, interpersonal communication skills, conflict management skills, team management, and confidence building.

Worklife

10.6 Reporting relationships are defined for all team members.

Guidelines

Reporting relationships are reflected in the organizational chart and understood by everyone in the organization. They are aligned with the organization's structure; the scope and type of services offered; efficient and effective leadership and teamwork throughout the organization; the types of team members; the flow of team members across the organization; and the integration of services across the continuum of care.

Worklife

10.7 Position profiles are developed for each position and are updated regularly.

Guidelines

The schedule for updating position profiles is established and followed by the organization's leaders.

Position profiles, also referred to as role descriptions, job descriptions, or position descriptions, align with the organization's mission, vision and values and contain a position summary as well as describing the roles and responsibilities of the position. They also outline the nature and scope of the work, the qualifications required for the position, reporting relationships, and lines of communication.

Safety

10.8 Roles and responsibilities for patient safety are defined in writing.

Guidelines

Everyone in the organization plays an important role in patient safety. Roles and responsibilities for patient safety may be defined in position profiles, performance appraisals, handbooks, and orientation material.


Safety

10.9 REQUIRED ORGANIZATIONAL PRACTICE: Patient safety training and education that addresses specific patient safety focus areas are provided at least annually to leaders, team members, and volunteers.

Guidelines

Annual education on patient safety is made available to the organization's leaders, team members, and volunteers. Specific patient safety focus areas such as safe medication use, reporting patient safety incidents, human factors training, techniques for effective communication, equipment and facility sterilization, handwashing and hand hygiene, and infection prevention and control are identified.

Test(s) for Compliance

Major 10.9.1 There is annual patient safety training tailored to the organization's needs and specific patient safety focus areas.


Worklife

10.10 Reporting relationships and leaders' span of control is regularly evaluated.

Guidelines

Evaluating reporting relationships and span of control includes regularly assessing leaders' training and competencies to fulfill position requirements and verifying that they have authority over the things for which they are accountable.

The frequency of evaluating reporting relationships and span of control is established and followed by the organization's leaders.


Worklife

10.11 Policies and procedures for monitoring team member performance align with the organization's mission, vision, and values.

Guidelines

The policies and procedures address having guidelines for expected behaviours that align with the organization's values (e.g., client- and family-centred care); giving regular, objective performance appraisals; documenting performance; and developing individual performance management plans based on strengths, areas for improvement, and individual goals and career plans.

The policies and procedures are shared with all team members.

Worklife

10.12 Policies and procedures regarding performance monitoring include how to deal with performance issues in an objective and fair way.

Guidelines

Dealing with performance issues may be influenced by collective agreements.

Worklife

10.13 An exit interview is offered to team members that leave the organization, and the information is used to improve performance, staffing, and retention.

Guidelines

Exit interview information is used to identify trends that may be used to improve staffing or retention strategies. For example, if many team members are leaving due to a lack of advancement opportunities, the organization may work to create new advancement opportunities or other incentives to encourage individuals to stay with the organization, e.g., professional development opportunities or opportunities for secondment.

Worklife

10.14 Human resource records are maintained for all team members.

Guidelines

The records include information about hiring; orientation, training, and education; performance appraisals and performance issues; and dismissal or resignation, including the exit interview.

Appropriateness

10.15 Human resource records are stored in a manner that protects individual privacy and meets applicable regulations.

Guidelines

The organization meets federal, and provincial or territorial regulations regarding privacy, and stores records for the required amount of time after an individual has left the organization.

11.0 Information management policies and systems meet current information needs, take into consideration future information needs, and enhance organizational performance.

Appropriateness

11.1 Information management systems selected for the organization meet the organization's current needs and take into consideration its future needs.

Guidelines

When choosing information management systems, the organization's leaders consider current and evolving information needs; hardware and software reliability, security, and user-friendliness; input from system users; available resources; and applicable legal requirements.

In some jurisdictions, selection and implementation of information management systems is the responsibility of government.

Appropriateness

11.2 The privacy and confidentiality of client information are protected, in accordance with applicable legislation.

Guidelines

Applicable legislation may be federal as well as provincial or territorial, e.g., the Personal Information Protection and Electronic Documents Act.

Appropriateness

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11.3 Policies and procedures to support the collection, entry, use, reporting, and retention of information are implemented and reviewed and updated regularly.

Guidelines

The organization's leaders decide on the frequency of reviewing and updating the policies and procedures.

Policies and procedures related to information management include standardized methods for collecting, coding, classifying, and entering data; education, training, and support so users can use the information system appropriately; maintaining confidentiality, security, and integrity of data and information; reporting data and information in a standardized and accurate way; and establishing retention and destruction timelines that specify how long information, including data and records, should be retained.

Client-centred Services

11.4 There are policies and processes to allow clients to easily access the information in their health record in a routine and timely way.

Guidelines

The policies and processes to access records are client-centred and support clients to access their information. Clients are the owners of their health information and as such are partners in the process of documenting information in their record, and can provide input on the information being documented. Clients have opportunities to discuss the information, ask questions, and provide feedback. Clients are informed of their right and the process to access information in their record.

Appropriateness

11.5 The organization's leaders manage access to and support and facilitate the flow of clinical and administrative information throughout the organization, to the governing body, across departments, sites, or regional boundaries, and to external partners and the community.

Guidelines

Information may be clinical or administrative. It may address clients, the team, safety, e.g., infection control, or organizational performance, e.g., quality, outcomes, or financial performance. Access is provided on an as-needed basis to protect privacy and meet applicable laws and regulations. To improve the flow of information, the organization's leaders may establish different levels of access, and adapt the information for each audience.

Appropriateness

11.6 Teams are provided with timely access to research-based evidence and leading and best practice information.

Guidelines

Access to research-based evidence and best practice information may differ among teams or units.

The organization's leaders collaborate with partners and other stakeholders to facilitate access to clinical information in a timely manner, including databases, books, or journals and evidence-based guidelines. This may include initiatives to expose leaders throughout the organization to research and best practice; developing library services or links to professional libraries to manage the organization's research and best practice information; or becoming involved in research networks or partnerships.

Appropriateness

11.7 The quality and usefulness of the organizations' data and information are regularly assessed, and the assessment results are used to improve the information systems.

Guidelines

The frequency of evaluating the quality and usefulness of data and information is established and followed by the organization's leaders.

The assessment includes processes and checkpoints to ensure that data and information are accurate, reliable, secure, confidential, and reported in a timely way. It may also include maintaining an inventory of existing information sources to support the integration of information coming from several sources; preventing unnecessary duplication, e.g., collection of the same information from multiple sources; pinpointing gaps and identifying new data collection fields; and encouraging a more complete approach to information management.

The organization's leaders seek input from users to ensure that the data and information provided are useful and relevant.

MONITORING AND IMPROVING QUALITY AND SAFETY

12.0 There is a process to manage and mitigate risk in the organization.

Appropriateness

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12.1 A structured process is used to identify and analyze actual and potential risks or challenges.

Guidelines

Analyzing potential risks involves evaluating and classifying the risk according to the likelihood of its occurrence and the potential severity of its impact or consequences.

Potential risks or challenges may include shifts in funding, political changes or labour disruptions, and human or other resource shortages.

By proactively identifying potential risks or challenges, the organization's leaders are able to mobilize resources quickly and effectively to prevent or limit crisis situations, and have mechanisms to ensure the continuity of operations in the event of a crisis.

Safety

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12.2 The organization's leaders implement an integrated risk management approach to mitigate and manage risk.

Guidelines

An integrated risk management approach means that risk management is integrated into the culture of the organization. The organization's leaders involve leaders throughout the organization in risk management planning and encourage them to consider risk management in day-to-day activities. This includes operational objectives or plans and the assignment of responsibilities and accountabilities throughout the organization.

The organization's leaders inform the governing body about real or potential risks facing the organization and work with it to incorporate risk management approaches into the strategic plan. Enterprise risk management, including organizational or administrative risk management, addresses financial, infrastructure, reputational and marketplace risks. It may include assessment of insurance protection, budget and capital planning processes; human resources; corporate governance; compliance risks associated with standards, policies, and legislation; information systems and technology; property and physical infrastructure; emergency or disaster preparedness; contract management; and risks related to reputation, credentialing, and liability.

Reducing clinical risks to clients and families and teams relates to providing safe and effective care and may address specific high-risk areas such as preventing and controlling infections, providing laboratory services, or other potential clinical risk areas identified by the organization. Integrated risk management tools and resources offered by the Healthcare Insurance Reciprocal of Canada (e.g., Risk Assessment Checklist program, Risk Register program) help organizations to identify and assess their top risks and to focus on key mitigation strategies to reduce these risks.

In organizations where there is no governing body, the organization's leaders take responsibility for integrating risk management into organizational decision-making.

Appropriateness

! 12.3 As part of the integrated risk management approach, the organization's leaders develop risk mitigation plans.

Guidelines

The organization's risk mitigation plans are based on the frequency and severity of the risk. They address identified risks or challenges and outline the actions to be taken by the organization to reduce the impact of incidents should they occur.

Appropriateness

12.4 The risk management approach and contingency plans are disseminated throughout the organization.

Appropriateness

12.5 The effectiveness of the integrated risk management approach is regularly evaluated and improvements are made as necessary.

Guidelines

The frequency of evaluation is established and followed by the organization's leaders.

Evaluating the effectiveness of the approach involves monitoring performance against pre-determined objectives and making improvements based on the results. This may include developing an internal audit that can be used to audit the risk management processes and procedures across the organization and identify areas for improvement. The internal audit is conducted on the processes or actions implemented as a result of the integrated risk management approach at various levels throughout the organization. The internal audit should include an analysis of the cost-effectiveness of the approach and monitoring risk performance indicators to evaluate the contribution of the integrated risk management approach to the organization.

Appropriateness

12.6 As part of the integrated risk management approach, established policies and procedures are followed for selecting and negotiating contracted services and contracted service providers.

Guidelines

The organization has policies and procedures for selecting contracted organizations or individual service providers; negotiating the terms of the agreement; signing, reviewing and updating all contracts; and anticipating and addressing risks associated with contracted services.

Appropriateness

12.7 As part of the integrated risk management approach, the quality of contracted services and contracted service providers is regularly evaluated.

Guidelines

The organization's leaders follow processes to monitor and evaluate the quality of the contracted services and contracted service providers in alignment with the evaluation of internal services, including ensuring that patient safety is maintained; dealing with disputes and issues of non-compliance with the code of conduct, policies, or procedures; and addressing areas for improvement.

13.0 Client flow is assessed and improved.

Client-centred Services

13.1 Client flow information is collected and analyzed in order to identify barriers to optimal client flow, their causes, and the impact on client experience and safety.

Guidelines

Barriers to optimal client flow include situations where the demand for services exceeds the organization's capacity to deliver those services, impairing seamless transitions through the continuum of care for clients. This may include waits, delays, bottlenecks, or back logs. Settings within the organization that are most likely to be barriers to efficient, optimal client flow include primary care, emergency departments (waits for inpatient admission), critical care units or post-anesthesia care units (waits for surgical care or medical care beds), inpatient units (waits for beds in the next setting of care), community settings (waits for long-term care, home care, home support, housing or palliative care).

Analyzing flow should include examining the system from the client's perspective and reviewing occupancy and how often clients are held in areas while they wait for another level or setting of care. Consider opportunities to review client feedback in surveys and more actively through client focus groups related to flow and during executive rounding opportunities. It may also include analyzing variability in demand for services including surgical volume trends or wait times for emergency care, surgical procedures, or long-term care and the organization's ability to meet those demands.

One approach for analyzing and optimizing client flow is the Lean methodology, which focuses on understanding the system from the client's experience in it and using that information to increase efficiency, minimize waste, and increase quality. There are many resources that can be used to apply Lean in healthcare (e.g., the Institute for Healthcare Improvement and the Lean Enterprise Institute). The Six Sigma methodology is another approach that can be used to improve quality and minimize variability in services.

Appropriateness

13.2 Information about barriers to client flow is used to develop a strategy to build the organization's capacity to meet the demand for service and improve client flow throughout the organization.

Guidelines

The client flow strategy may be across a province, health region, network of health care institutions, or stand-alone health care organization. Teams, clients, and families are involved in the process of developing the client flow strategy. Once the barriers or challenges and their causes are identified, improving client flow may include addressing inefficient or unsafe activities or processes that contribute to the inefficient flow of clients through the organization.

Improving client flow may require evaluating and improving triage processes; adding or shifting bed capacity or having surge capacity policies and procedures, including thresholds for creating extra capacity; improving bed-cleaning turnaround times; improving the transfer of information between departments or services; establishing which clients or cases have priority for beds and protecting beds for those that are prioritized; or balancing the surgical schedule with elective and non-elective surgeries so that there is room for flexibility in carrying out unscheduled or emergency surgeries.

Continuity

13.3 The organization's leaders collaborate with other service providers and partners to improve and optimize client flow.

Guidelines

The organization's leaders develop partnerships with service providers outside the organization such as consultants (e.g., diagnostic testing), acute care and primary care providers, outpatient clinics, and long-term care organizations to improve client flow issues at admission and discharge. One approach is to establish guidelines for determining the most appropriate setting of care (e.g., which clients should be sent to the emergency department as opposed to receiving primary care).

Safety

13.4 REQUIRED ORGANIZATIONAL PRACTICE: Client flow is improved throughout the organization and emergency department overcrowding is mitigated by working proactively with internal teams and teams from other sectors.

NOTE: This ROP only applies to organizations with an emergency department that can admit clients.

Guidelines

Emergency department (ED) overcrowding is a system-wide challenge. Its root cause is usually poor client flow (e.g., unavailability of inpatient beds, inappropriate admissions, delays in the decision to admit, delays in discharge, and lack of timely access to diagnostic services and care in the community) stemming from a mismatch between capacity and demand. By evaluating client flow data and considering all sources of demand (such as emergency and planned admissions, outpatient and follow-up care), organizations can understand the pattern of demand and develop strategies to meet variations in demand, reduce barriers to client flow, and prevent overcrowding. The approach should be aligned with existing provincial and territorial indicators and strategies.

The approach specifies the role of clinical and non-clinical teams within the hospital (e.g., medicine, surgery, infection control, diagnostics, housekeeping, admitting, discharge planning, and transportation) and across the health system (e.g., long-term care, home care, palliative care, rehabilitation, and primary care).

Possible interventions to address variations in demand and barriers to flow include developing clear criteria for admission, reducing the length of stay (especially for those with extended lengths of stay), improving access to ambulatory services (diagnostics, laboratory, and consults), improving discharge planning, and partnering with the community to improve placement times. To know whether the intervention(s) led to an improvement, organizations need to continue to analyze client flow.

Improving client flow requires strong leadership support. The accountability of senior leaders, including physicians, can be demonstrated through policy, through their specified roles and responsibilities, or through performance evaluation.

Test(s) for Compliance

Major	13.4.1	The organization's leaders, including physicians, are held accountable for working proactively to improve client flow and mitigate emergency department overcrowding.

Major	13.4.2	Client flow data (e.g., length of stay, turnaround times for labs or imaging, community placement times, consultant response times) is used to identify variations in demand and barriers to delivering timely emergency department services.
Major	13.4.3	There is a documented and coordinated approach to improve client flow and address emergency department overcrowding.
Major	13.4.4	The approach specifies the role of teams within the hospital and other sectors of the health system to improve client flow.
Major	13.4.5	The approach specifies targets for improving client flow (e.g., time to transfer clients to an inpatient bed following a decision to admit, emergency department length of stay for non-admitted clients, transfer of care times from emergency medical services to the emergency department).
Major	13.4.6	Interventions to improve client flow that address identified barriers and variations in demand are implemented.
Major	13.4.7	When needed, short-term actions to manage overcrowding, that mitigate risks to client and team members (e.g., over-capacity protocols), are implemented.
Minor	13.4.8	Client flow data is used to measure whether the interventions prevent or reduce overcrowding in the emergency department, and improvements are made when needed.

Appropriateness

13.5 The effectiveness and impact of the client flow strategy is evaluated.

14.0 **The organization is prepared for disasters and emergencies.**


Safety

14.1 Plans for preventing and mitigating potential disasters and emergencies are developed and implemented.

Guidelines

Prevention refers to measures taken to avoid an incident or stop an emergency or disaster from occurring. Mitigation refers to actions taken to reduce the risks and impacts posed by hazards.

Prevention and mitigation plans should be based on information obtained from hazard identification, risk assessment, and business impact analysis.


Safety

14.2 An all-hazard disaster and emergency response plan is developed and implemented.

Guidelines

The plan identifies immediate actions to respond to disasters and emergencies including internal and external functional roles and responsibilities (e.g., those of community partners) and establishes lines of authority. The plan addresses all hazards identified by the organization's leaders, risk assessment, and business impact analysis.

Organizations with two or more sites follow the same or similar plans to prepare for and reduce the risk of disasters and emergencies.


Appropriateness

14.3 The all-hazard disaster and emergency response plan is aligned with those of partner organizations and local, regional, and provincial governments.

Guidelines

The organization's disaster and emergency plans are integrated with partner organizations and governments to facilitate coordinated, large-scale responses as required.

Appropriateness

14.4 Education is provided to support the all-hazard disaster and emergency response plan.

Guidelines

The objective of the education is to create awareness and enhance the skills required to develop, implement, maintain, and execute the all-hazard disaster and emergency response plan.

The education may include the emergency response plans and processes, advanced first aid (how to sustain life and prevent further injuries); field triage (sorting clients into those who need critical attention and immediate medical attention and those with less serious injuries); or the use of altered care standards (e.g., when demand for care provided in accordance with current standards exceeds resources) including conditions under which altered care standards are activated, how emergency responders will be notified of the activation, and how to apply altered care standards in the field.

Safety

14.5 The organization's all-hazard disaster and emergency response plans are regularly tested with drills and exercises to evaluate the state of response preparedness.

Guidelines

Depending on the level of risk, regular testing of at least one type of emergency or one element of the plan is done at least quarterly and annual evacuation drills are held for each shift. The timing and frequency of drills and exercises may depend on the time sensitivity or complexity of the emergency plans. A facility that experiences a high degree of turnover may need more frequent exercises. Often training and exercise schedules can be linked to seasonal hazards or to trigger events.

The organization's leaders encourage as many team members as possible to participate in testing disaster and emergency plans, and monitor and document participation.

Safety

14.6 The results from post-drill analysis and debriefings are used to review and revise the all-hazard disaster and emergency response plans and procedures as necessary.

Appropriateness

14.7 An incident management system is developed and implemented to direct and coordinate actions and operations during and after disasters and emergencies.

Guidelines

An incident management system (also known as an emergency management system) is a system that defines the roles and responsibilities of team members and the operating procedures to be used in the management of emergencies and other events. The roles and responsibilities will vary depending on the form of emergency or disaster.

Appropriateness

14.8 An emergency communication plan is developed and implemented.

Guidelines

The communication plan identifies the essential information and messages that must be sent and received, to whom they should be communicated, and how the organization will send communications internally and externally, including to the public.

Appropriateness

14.9 A business continuity plan is developed and implemented in order to continue critical operations during and following a disaster or emergency.

Guidelines

The business continuity plan is based on the results of business impact analysis, and includes the identification of time-sensitive critical functions and applications, associated resource requirements, and interdependencies.

Appropriateness

14.10 The business continuity plan addresses back-up systems for essential utilities and systems during and following emergency situations.

Guidelines

Utilities include electricity, potable water, sterile water, fuel, medical gases, and vacuum systems.

Systems include elevators/escalators; heating, ventilation, and cooling systems; steam for sterilization; communication equipment such as telephones, facsimile machines, mobile phones, pagers, and intercoms; and information systems.

Population Focus

14.11 When disasters or emergencies occur, teams, clients, and the community are provided with support and debriefing opportunities.

Guidelines

Depending on the scope of the disaster or emergency, the opportunity to debrief could entail a small, informal meeting with those involved, or something larger such as an open forum with partners and the community.

15.0 **Patient safety is monitored and improved on an ongoing basis.**


Safety

15.1 REQUIRED ORGANIZATIONAL PRACTICE: A patient safety plan is developed and implemented for the organization.

Guidelines

There is an important connection between excellence in care and safety. Ensuring services are provided safely is one of an organization's primary obligations to clients and team members. Patient safety can be improved when organizations develop a targeted patient safety plan.

Patient safety plans need to consider safety issues in the organization, the delivery of services, and the needs of clients and families. They may include a range of topics and approaches, such as mentoring team members, the role of leadership (e.g., patient safety leadership walkabouts), implementing organization-wide patient safety initiatives, accessing evidence and best practices, and recognizing team members for innovations to improve patient safety.

Test(s) for Compliance

Major	15.1.1	Patient safety issues for the organization are assessed.
Minor	15.1.2	There is a plan and process in place to address identified patient safety issues.
Major	15.1.3	The plan includes patient safety as a written strategic priority or goal.

	Minor	15.1.4	Resources are allocated to support the implementation of the patient safety plan.
 Safety		15.2	Responsibility for implementing and monitoring the patient safety plan and for leading patient safety improvement activities is assigned to a council, committee, group, or individual. **Guidelines** Responsibility for the patient safety plan may be assigned to a council, committee, or team whose mandate includes organization-wide patient safety; a designated team member with responsibility for patient safety; or patient safety champions whose mandate is to facilitate and improve patient safety throughout the organization or within specific work areas.
 Safety	!	15.3	A strategy to prevent the abuse of clients is developed and implemented.

Guidelines

Abuse includes all improper treatment of a client. Types of abuse include physical abuse, verbal abuse, emotional abuse, financial abuse or exploitation, sexual abuse, and neglect.

It is important to identify risk factors within the organization that make the potential for abuse and neglect more likely. These include:
• organization risk factors (e.g., low staffing, team stress and burnout, high turnover, negative organizational culture, absence of an abuse prevention policy)
• client risk factors (e.g., dementia, high degree of dependence, social isolation)
• client relationship risk factors (e.g., past conflicts with the team or with their family, little to no contact with family)

An organizational strategy to prevent abuse can include many factors, including a policy on abuse prevention; education for teams, clients, and families; tools to identify clients at risk for abuse; and an abuse reporting protocol.

Creating an abuse prevention policy is a good first step in reducing the risk of abuse within an organization. The policy should include information on how to recognize the signs and symptoms of abuse, and reporting and investigation procedures, and should be consistent with legislation. Team education and training is critical in prevention of abuse, and should include such topics as communication skills, anger management, behaviors or symptoms that put an individual at risk for abuse such as mental illness or dementia, and how to respond appropriately to issues and confrontations.

Resources:
College of Nurses of Ontario – Abuse Prevention: One is One Too Many
Fraser Health – Adult Abuse and Neglect.

Safety ROP 15.4

REQUIRED ORGANIZATIONAL PRACTICE: A patient safety incident management system that supports reporting and learning is implemented.

Guidelines

In a culture of patient safety, everyone is encouraged to report and learn from patient safety incidents, including harmful, no-harm, and near miss. A reporting system that is simple (few steps), clear (what needs to be reported, how to report, and to whom), confidential, and focused on system improvement is essential. Clients and families may report patient safety incidents differently than team members, but everyone needs to know how to report. Information about how to report can be tailored to the needs of team members or clients, and can be part of team member training and included in written and verbal communication to clients and families about their role in safety.

The immediate response to a patient safety incident is to address the urgent care and support needs of those involved. It is also important to secure any items related to the incident (for testing and review by the analysis team), report the incident using the approved process, begin the disclosure process (if required), and take action to reduce any risk of imminent recurrence.

Through incident analysis (also known as 'root cause analysis'), contributing factors and recommended actions can be identified in order to make improvements. Analyzing similar patient safety incidents (such as near misses) together, to look for patterns or trends, can yield helpful information, as can analyzing incidents in isolation. Communicating incident analysis findings broadly (e.g., with clients and families, governance, leadership, clinical teams, and external partners) builds confidence in the incident management system and promotes learning from patient safety incidents.

The Canadian Patient Safety Institute has developed resources for patient safety incident management. Global Patient Safety Alerts is an on-line, searchable database where lessons learned from patient safety incidents are shared.

Test(s) for Compliance

Major	15.4.1	A patient safety incident management system is developed, reviewed, and updated with input from clients, families, and team members, and includes processes to report, analyze, recommend actions, and monitor improvements.

Major	15.4.2	Information is shared with clients, families, and team members so they understand what, when, and how to report patient safety incidents.
Major	15.4.3	Training is provided, and documented, for team members on the immediate response to patient safety incidents.
Major	15.4.4	There are procedures to review patient safety incidents and established criteria are used to prioritize those that will be analyzed further.
Major	15.4.5	All recommended actions resulting from the analysis of patient safety incidents are reviewed and the rationale to accept, reject, or delay implementation is documented.
Major	15.4.6	Information about recommended actions and improvements made following incident analysis is shared with clients, families, and team members.
Minor	15.4.7	The effectiveness of the patient safety incident management system is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Gathering feedback from clients, families, and team members about the system • Monitoring patient safety incident reports by type and severity • Examining whether improvements are implemented and sustained • Determining whether team members feel comfortable reporting patient safety incidents (e.g., based on results from the Canadian Patient Safety Culture Survey Tool).

Safety

15.5 The organization's leaders support a just culture and provide opportunities for team members to learn from patient safety incidents.

Guidelines

A just culture encourages team members to report safety incidents. It promotes a judgment-free environment where the focus is on improving systems and learning from patient safety incidents, while recognizing team members' professional accountability. In a just culture, the response to an incident is fair, consistent, and supportive - thereby promoting further incident reporting. When safety incidents occur in a just culture, it becomes an opportunity to review the contributing factors and discuss ways to prevent the incident from happening again.

The Canadian Patient Safety Institute and Safer Health Care Now! provide useful resources for learning about patient safety and improving the safety and quality of services.

Safety

15.6

REQUIRED ORGANIZATIONAL PRACTICE: A documented and coordinated approach to disclosing patient safety incidents to clients and families, that promotes communication and a supportive response, is implemented.

Guidelines

Disclosure of patient safety incidents is an ongoing discussion that includes the following core elements:
• Informing those affected that a patient safety incident has occurred and offering an apology
• Explaining what happened and why, as facts are known
• Discussing the immediate actions taken to care for the client and mitigate further harm
• Reviewing recommended actions to prevent future incidents
• Offering support to all involved

The support provided meets the needs of those involved (clients, families, and the team), and can be practical (e.g., reimbursement for out-of-pocket expenses) or emotional/psychological (e.g., helping with access to support groups or offering counselling).

Disclosing a patient safety incident that affects multiple clients (e.g., failures in sterilization, privacy breeches) includes additional elements, for example:
• Identifying which clients have been exposed to risk
• Deciding which clients should be contacted and how
• Locating and communicating with clients who have been affected
• Informing the community, other organizations, and the media

When asked for their feedback, clients and families are encouraged to speak from their own perspective and in their own words about their experience.

The Canadian Disclosure Guidelines and Guidelines for Informing the Media after an Adverse Event are resources for developing and implementing a transparent and supportive disclosure process.

Test(s) for Compliance

Major	15.6.1	There is a documented and coordinated process to disclose patient safety incidents to clients and families that identifies: • Which patient safety incidents require disclosure • Who is responsible for guiding and supporting the disclosure process • What can be communicated and to whom about the incident • When and how to disclose • Where to document the disclosure.
Minor	15.6.2	The disclosure process is reviewed and updated, if necessary, once per accreditation cycle, with input from clients, families, and team members.
Major	15.6.3	Those responsible for guiding and supporting the disclosure process are provided with training on disclosure.
Major	15.6.4	Communication occurs throughout the disclosure process with clients, families, and team members involved in the patient safety incident. Communication is documented and based on their individual needs.
Major	15.6.5	As part of the disclosure process, practical and emotional/psychological support is offered to clients, families, and team members involved in the patient safety incident.
Minor	15.6.6	Feedback is sought from clients, families, and team members about their experience with disclosure and this information is used to make improvements, when needed, to the disclosure process.

Safety ROP 15.7 REQUIRED ORGANIZATIONAL PRACTICE: A documented and coordinated medication reconciliation process is used to communicate complete and accurate information about medications across care transitions.

Guidelines

Medication reconciliation is recognized as an important safety initiative by the World Health Organization. Medication reconciliation can be a cost-effective way to reduce medication errors (e.g., omissions, duplications, incorrect orders) and the re-work often associated with medication management.

Medication reconciliation is a three-step process, whereby the team (e.g., physicians, nurses, pharmacists) works in partnership with clients and families to generate a Best Possible Medication History (BPMH), that identifies and resolves medication discrepancies, and communicates a complete and accurate list of medication to the client and their next care provider.

An organizational policy signals leadership's commitment to medication reconciliation and provides overarching guidance (e.g., an overview of the process, roles and responsibilities, care transitions where medication reconciliation is required, exemptions). Allocating resources to staffing, education, tools, information technology, etc., also demonstrates a commitment to medication reconciliation. Team education should include the rationale for and steps involved in medication reconciliation.

Implementing and sustaining medication reconciliation throughout an organization will be more successful if it is led by an interdisciplinary coordination team. Depending on the organization, the coordination team could include senior leaders (including clinical leaders representing medicine, nursing, and pharmacy); team members who are directly involved in the process; information technology staff; representatives from quality, risk, and safety committees; and clients and families.

It is important to monitor, in consultation with the coordination team and clinical team members, whether the medication reconciliation policy is being followed (e.g., Do clients receive medication reconciliation? Is the BPMH documented?) and the quality of the process (e.g., Is the BPMH complete? Are medication discrepancies identified and resolved?).

Test(s) for Compliance

Major	15.7.1	There is a medication reconciliation policy and process to collect and use accurate and complete information about clients' medication at care transition.

Major	15.7.2	Roles and responsibilities for completing medication reconciliation are defined.
Minor	15.7.3	An organizational plan to sustain medication reconciliation is led by an interdisciplinary coordination team.
Major	15.7.4	There is documented evidence that team members (including physicians) who are responsible for medication reconciliation are provided with relevant education.
Minor	15.7.5	Compliance with the medication reconciliation process is monitored and improvements are made when required.


Safety

15.8 At least one patient safety-related prospective analysis has been conducted within the last year and appropriate improvements are made as a result.

Guidelines

Conducting systematic prospective analyses of potential patient safety incidents is an effective method to prevent or reduce errors. The intent is to eliminate unsafe actions and conditions that can lead to harmful incidents. For example, significant improvement was noted when a Failure Modes and Effects Analysis (FMEA) was applied to two high-risk situations—transcription of medication errors for inpatients and overcrowding in the emergency department. There are numerous tools and techniques available to conduct a prospective analysis. FMEA is a team-based, systematic, and proactive approach that identifies the ways a process or design might fail, why it might fail, the effects of that failure, and how it can be made safer. Other methods to proactively analyze key processes include fault tree analysis, hazard analysis, simulations, and Reason's Errors of Omissions model.


Safety

15.9 ACCREDITATION CANADA REQUIRED INSTRUMENT: The organization's patient safety culture is monitored by using the Canadian Patient Safety Culture Survey Tool.

Guidelines

The organization's leaders recognize their responsibility for promoting a culture of patient safety, for preventing patient safety incidents, for allocating resources to improve safety, and for fostering a no-blame culture that encourages learning from errors and mistakes. The Canadian Patient Safety Culture Survey Tool measures these and other elements to determine organizational commitment to client safety.

The organization shares the results of the Canadian Patient Safety Culture Survey Tool with team members, and is able to demonstrate that the results have been used to improve patient safety.

Instrument Information

Major

15.9.1 The Canadian Patient Safety Culture Survey Tool is administered at least once per accreditation cycle.

15.9.2 Action has been taken on the most recent Canadian Patient Safety Culture Survey Tool results.

Safety

15.10 REQUIRED ORGANIZATIONAL PRACTICE: The governing body is provided with quarterly reports on patient safety that include recommended actions arising out of patient safety incident analysis, as well as improvements that were made.

Guidelines

The governing body is ultimately accountable for the quality and safety of the services delivered by the organization. It plays an important role in enabling an organizational culture that enhances patient safety.

An organization is more likely to make safety and quality improvement a central feature if the governing body is aware of patient safety issues and patient safety incidents, and leads the organization's quality improvement efforts. In addition, the governing body needs to be informed about and have input into follow-up actions or improvement initiatives resulting from patient safety incidents. Outcomes and processes of care are improved in organizations where the governing body is engaged in patient safety.

Test(s) for Compliance

Major	15.10.1	Quarterly patient safety reports are provided to the governing body.
Minor	15.10.2	The quarterly patient safety reports outline specific organizational activities and accomplishments in support of the organization's patient safety goals and objectives.
Minor	15.10.3	The governing body supports the patient safety activities and accomplishments and acts on the recommended actions in the quarterly patient safety reports.

16.0 There is a defined and integrated quality management system used to assess performance and improve quality.

Appropriateness

16.1 An integrated quality improvement plan is developed and implemented.

Guidelines

An integrated quality improvement plan incorporates risk and utilization management; performance measurement, including monitoring strategic goals and objectives; patient safety; and quality improvement. It recognizes that these activities are interrelated and therefore need to be coordinated.

As part of the integrated quality improvement plan, the organization's leaders may use a balanced scorecard, which allows alignment of performance measurement and quality improvement with strategic goals and objectives, or to translate the strategy into operational actions. Involving relevant departments and leaders at all levels in achieving the strategic goals and objectives is important. The scorecard is adaptable to the organization's goals and objectives. It may address financial issues; client and team experience; and internal systems or process performance information.

Using information from the scorecard, the organization's leaders can share performance information with the governing body, where appropriate; generate dashboards or scorecards for specific programs, units or teams; generate client or team experience reports; and generate information related to other system-wide measures.

One approach for analyzing and improving processes and the overall quality of a health care organization is the Lean methodology, which focuses on understanding the system from the client's experience in it and using that information to increase efficiency, minimize waste, and increase quality. There are many resources that can be used to apply Lean methodology in healthcare quality improvement (e.g. the Institute for Healthcare Improvement and the Lean Enterprise Institute). The Six Sigma methodology is another approach that can be used to improve quality and minimize variability in services. This approach uses data and statistical analysis to identify where errors are occurring and make improvements.

The British Columbia Patient Safety and Quality Council offers quality improvement and patient safety educational programs online. The Health Quality Ontario website offers quality improvement guides addressing models for improvement, methods, and tools; access; efficiency; and long-term care.

Appropriateness

16.2

A defined process is followed to select and monitor system-level process and outcome measures to evaluate the organization's performance at a strategic level.

Guidelines

At a strategic level, the organization's leaders select system-wide measures that allow them to assess the organization's overall performance. These measures are often referred to as “big-dot” measures or indicators. They are used to assess the organization's performance over time and in relation to strategic goals and objectives; to compare the organization's performance to that of other organizations; and to plan strategic goals and objectives and quality improvement initiatives.

These measures may reflect the continuum of care (e.g., primary health care, acute care, long-term care and home care) and may address themes such as access, length of stay, patient safety, client- and family-centredness, client experience, or health human resources. Organizations should select measures according to how they are aligned with provincial and national priorities and with their own strategic goals for quality improvement.

The organization's leaders work with the governing body, where applicable, to select process and outcome measures that are relevant and appropriate and linked to strategic goals and objectives.

In organizations where there is no governing body, the organization's leaders take responsibility for selecting and monitoring the organization's process and outcome measures.

Appropriateness

16.3

The organization's leaders require, monitor, and support service, unit, or program areas to monitor their own process and outcome measures that align with the broader organizational strategic goals and objectives.

Guidelines

The organization's leaders obtain a balanced perspective of the organization as a whole by using a set of system-wide measures that are complemented with micro-level measures or indicators related to the performance of services, units, or program areas.

Service or program area-level measures address service delivery effectiveness, responsiveness, client- and family-centredness, client experience, and client outcomes. Using performance data for their team, teams are able to determine whether they are achieving their goals and objectives, where performance deficiencies exist, and areas for improvement.

Client-centred Services

16.4

The organization has uploaded a client experience report for applicable services. Please refer to the current client experience requirement documentation in the client portal for more information.

Guidelines

Organizations are required to conduct a client experience survey in each of the following services (if offered):

- Acute care
- Long-term care
- Home care
- Home support
- Primary care
- Mental health

Medical imaging centres, correctional services, and the Canadian Forces health system are also required to conduct a client experience survey.

Client-centred Services

16.5

Action has been taken on the client experience tool results.

Appropriateness

16.6

Opportunities for quality improvement are identified based on trends in patient safety incidents, performance data, patient experience data, feedback from Client and Family advisory councils and other sources, and plans are developed to prioritize and address those opportunities.

Guidelines

Other sources of data used to identify areas for improvement include health outcomes, e.g., changes in the health status of the populations served by the organization; client, community, and team satisfaction results; complaints; information about the appropriateness of the organization's services; results of utilization reviews, e.g., cost-effectiveness and efficiency; and the level of integration achieved and the continuity of service.

Opportunities for performance improvement are prioritized based on the community's health needs; areas that are high risk, high volume, high cost, or problem-prone; and alignment with strategic goals and objectives.

Appropriateness

16.7

The organization's leaders verify that the quality improvement plans and related changes are implemented.

Guidelines

To achieve organization-wide improvements, the organization's leaders identify opportunities for improvement and verify that the corresponding changes and improvements are implemented. Teams, clients, and families are involved in interpreting the results, solving problems, and making improvements.

Appropriateness

16.8

Regular reports about the organization's performance are generated and shared with the governing body, where applicable.

Guidelines

The frequency of performance reporting is established and followed by the organization's leaders, and governing body, where applicable. The reports include information about current performance, including opportunities for improvement, as well as plans or initiatives to improve performance.

The reports are shared with the governing body to keep it informed about the organization's performance, priorities for improvement, and results. In organizations where there is no governing body, the organization's leaders take responsibility for monitoring the organization's performance and initiatives to improve performance.

Population Focus

16.9

Reports about the organization's performance and quality of services are shared with the team, clients, families, the community served, and other partners and stakeholders.

Guidelines

The frequency of performance reporting is established by the governing body and the organization's leaders. The reports include information about current performance, including opportunities for improvement, as well as plans or initiatives to improve performance.

Appropriateness

16.10

The results of the organization's quality improvement activities are communicated broadly, as appropriate.

Guidelines

Broad communication of the results of quality improvement activities includes communicating with the governing body, where applicable; teams; and clients and families. Results of quality improvement activities may also be shared with partners, stakeholders, and the community as a whole.

When results of quality improvement activities are communicated, it is done in accordance with legislation that protects information related to quality, safety, risk management, and personal health information.

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Feedback: Please indicate the name of the standard, as well as the criterion number in your comments. Please be as specific as possible in your comments.

For example: I would like to provide comments on the Long-Term Care Services standards, criterion 3.12. Clients should be included in this process. I suggest you change the wording to "The team engages staff, service providers, and clients in the process to plan services."

You may also submit your feedback online HERE

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